Reprinted
February 24, 2004

ENGROSSED
HOUSE BILL No. 1273

DIGEST OF HB 1273 (Updated February 23, 2004 4:59 pm - DI 44)

Citations Affected: IC 27-8; noncode.

Synopsis: ICHIA amendments. Amends the comprehensive health insurance association (ICHIA) law concerning: (1) premium rates; (2) assessments; (3) tax credits; (4) reporting requirements; (5) member and health care provider grievances; (6) reimbursement rates; (7) provider contracting; (8) balance billing. Makes technical corrections and conforming amendments. Repeals sections concerning Medicaid payment programs. Makes an appropriation.

Effective: January 1, 2004 (retroactive); March 15, 2004 (retroactive); April 1, 2004; July 1, 2004; January 1, 2005.

Fry, Ripley
(SENATE SPONSORS — MILLER, LANANE, BRODEN)

January 15, 2004, read first time and referred to Committee on Insurance, Corporations and Small Business.
January 29, 2004, amended, reported — Do Pass.
February 2, 2004, read second time, ordered engrossed.
February 3, 2004, engrossed.
February 5, 2004, read third time, passed. Yeas 94, nays 1.

SENATE ACTION

February 10, 2004, read first time and referred to Committee on Finance.
February 19, 2004, amended, reported favorably — Do Pass.
February 23, 2004, read second time, amended, ordered engrossed.

Reprinted
February 24, 2004

Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

ENGROSSED HOUSE BILL No. 1273

A BILL FOR AN ACT to amend the Indiana Code concerning insurance and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-10-2.1, AS AMENDED BY P.L.178-2003, SECTION 63, AND P.L.193-2003, SECTION 4, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2005]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of ~~*seven (7)*~~ *nine (9)* members whose principal residence is in Indiana selected as follows:

(1) ~~*Three*~~ ~~*(3)*~~ *Four (4)* members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

(4) One (1) member to be appointed by the commissioner must be a representative of health care providers.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) **Subject to section 2.6 of this chapter,** sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in

relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association. ~~*and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.*~~

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(15) Subject to section 3 of this chapter, negotiate reimbursement rates and enter into contracts with individual health care providers and health care provider groups.

(f) ~~*The board shall obtain an actuarial recommendation for development of an equitable methodology for determination of member assessments.*~~

~~*(g)*~~ Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may ~~*not*~~ be:

(1) not more than one hundred fifty percent (150%) of the average

premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year *for an insured whose family income is less than three hundred fifty-one percent (351%) of the federal income poverty level for the same size family; and*

(2) an amount equal to:

(A) not less than one hundred fifty-one percent (151%); and

(B) not more than two hundred percent (200%);

of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year, for an insured whose family income is more than three hundred fifty percent (350%) of the federal income poverty level for the same size family.

Additionally, the association may, on October 1 of each year, adjust the rates as described in section 2.2 of this chapter. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits **substantially** identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) ~~*(h)*~~ Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. **Twenty-five percent (25%) of** any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums **as reported to the department of insurance,** excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association. ~~or any other equitable basis as may be provided in the plan of operation. *For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided.*~~ **Seventy-five percent (75%) of any net loss shall be paid by the state.** In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial

capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. ~~*Except as provided in sections 12 and 13 of this chapter,*~~ Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) ~~*(i)*~~ The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) ~~*(j)*~~ The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) ~~*(k)*~~ All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) ~~*(l)*~~ The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

~~*(l) The association shall pay an agent's insurance producer's referral fee of twenty-five dollars ($25) to each insurance agent producer who refers an applicant to the association if that applicant is accepted.*~~

~~(m)~~ **(l)** The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

~~(n)~~ **(m)** Members who, ~~after July 1, 1983,~~ during any calendar year, have paid one (1) or more assessments levied under this chapter may ~~either:~~

~~(1) take a credit against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or~~

~~(2)~~ any ~~member insurer may~~ include in the rates for premiums charged for insurance policies to which this chapter applies

amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

~~(o)~~ **(n)** The association shall provide for the option of monthly collection of premiums.

(o) The association shall periodically certify to the budget agency the amount necessary to pay seventy-five percent (75%) of any net loss as specified in subsection (g).

SECTION 2. IC 27-8-10-2.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 2.2. (a) Subject to subsection (b), a premium rate calculated under section 2.1 of this chapter may, on October 1 of each year, be adjusted by an amount equal to:**

(1) the percentage change in medical cost experienced by the association; minus

(2) the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics;

during the preceding calendar year.

(b) A positive or negative adjustment in the rate calculated under subsection (a) may not be greater than ten percent (10%).

SECTION 3. IC 27-8-10-2.3, AS ADDED BY P.L.167-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 2.3. **(a)** A member shall, not later than October 31 of each year, certify an independently audited report to the:

(1) association;

(2) legislative council; and

(3) department of insurance;

of the amount of tax credits taken against assessments by the member under section ~~2.1(n)(1)~~ **2.1 (as in effect December 31, 2004) or 2.4** of this chapter during the previous calendar year.

(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter as of the date of the report.

SECTION 4. IC 27-8-10-2.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2005]: **Sec. 2.4. (a) Beginning January 1, 2005, a**

member that, before January 1, 2005, has:

(1) paid an assessment; and

(2) not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, for each taxable year beginning after December 31, 2006, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each taxable year.

(c) If the maximum amount of a tax credit determined under subsection (b) for a taxable year exceeds a member's liability for the taxes described in subsection (b), the member may carry the unused portion of the tax credit forward to subsequent taxable years. Tax credits carried forward under this subsection are not subject to the ten percent (10%) limit set forth in subsection (b).

(d) The total amount of credits taken by a member under this section in all taxable years may not exceed the total amount of assessments paid by the member before January 1, 2005, minus the total amount of tax credits taken by the member under section 2.1 of this chapter (as in effect December 31, 2004) before January 1, 2005.

SECTION 5. IC 27-8-10-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 2.5. (a) A member shall comply with the association's plan of operation.**

(b) A member assessment under section 2.1 of this chapter is due not more than thirty (30) days after the member receives written notice of the assessment. A member that pays an assessment after the due date shall pay interest on the assessment at the rate of six percent (6%) per annum.

SECTION 6. IC 27-8-10-2.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 2.6. (a) If a:**

(1) member is aggrieved by an act of the association; or

(2) health care provider is aggrieved by an act of the association with respect to reimbursement to the provider

under an association policy;

the member or health care provider shall, not more than ninety (90) days after the act occurs, appeal to the board of directors for review of the act.

(b) If:

(1) within thirty (30) days after an appeal is filed under subsection (a), the board of directors has not acted on the appeal; or

(2) a member or health care provider is aggrieved by a final action or decision of the board of directors;

the member or health care provider may appeal to the commissioner.

(c) An appeal to the commissioner under subsection (b) must be filed less than thirty (30) days after the:

(1) expiration of the thirty (30) day period specified in subsection (b)(1); or

(2) action or decision specified in subsection (b)(2).

(d) The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the appeal.

(e) A final action or order of the commissioner on an appeal filed under this section is subject to judicial review.

(f) If a member or health care provider sues the association, the court shall not award to the member or health care provider:

(1) attorney's fees or costs; or

(2) punitive damages.

SECTION 7. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 15, 2004 (RETROACTIVE)]: Sec. 3. (a) An association policy issued under this chapter may pay **an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy must be based on one (1) or any combination of the following reimbursement methods, as determined by the board of directors:**

(1) The association's usual and customary fee schedule in effect on January 1, 2004. If payment is based on the usual and customary fee schedule in effect on January 1, 2004, the rates of reimbursement under the fee schedule must be adjusted annually by a percentage equal to the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published

by the United States Bureau of Labor Statistics during the preceding calendar year.

(2) A health care provider network arrangement. If payment is based on a health care provider network arrangement, reimbursement under an association policy must be made according to:

(A) a network fee schedule for network health care providers and nonnetwork health care providers; and

(B) any additional coinsurance that applies to the insured under the association policy if the insured obtains health care services from a nonnetwork health care provider.

(3) A fee schedule not described in subdivision (1) or (2). If payment is based on a fee schedule not described in subdivision (1) or (2), a health care provider must be reimbursed for medically necessary eligible expenses at a rate equal to the Medicare reimbursement rate for the eligible expenses plus eight and one-half percent (8.5%). ~~usual and customary charges or use other reimbursement systems that are consistent with managed care plans, including fixed fee schedules and capitated reimbursement, for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter.~~

(b) Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

~~(b)~~ **(c)** A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

~~(c)~~ **(d)** This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

~~(d)~~ **(e)** For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be

determined on the basis of their monetary equivalency.

~~(e)~~ **(f)** The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

~~(f)~~ **(g)** The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

~~(g)~~ **(h)** This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit to the citizens of Indiana.

~~(h)~~ **(i)** This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may

take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

SECTION 8. IC 27-8-10-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 2004]: **Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:**

(A) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(B) any copayment, deductible, or coinsurance amounts applicable under the association policy.

SECTION 9. IC 27-8-10-14, AS ADDED BY P.L.193-2003, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 14. (a) Notwithstanding section 2.1 of this chapter: ~~for the period beginning July 1, 2003, and ending March 15, 2004:~~

(1) fifty percent (50%) of any net loss determined under ~~section 2.1(g)~~ **section 2.1** of this chapter shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association; and

(2) fifty percent (50%) of any net loss determined under ~~section 2.1(g)~~ **section 2.1** of this chapter shall be assessed by the association to all members in proportion to their respective shares of the number of individuals in Indiana who are covered under health insurance provided by a member, excluding individuals who are covered under Medicaid contracts with the state during the calendar year coinciding with or ending during the fiscal year of the association.

(b) This section expires ~~March 15, 2004.~~ **January 1, 2005.**

SECTION 10. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2004]: IC 27-8-10-12; IC 27-8-10-13.

SECTION 11. [EFFECTIVE JANUARY 1, 2005] **The amounts certified to the budget agency under IC 27-8-10-2.1(o), as amended by this act, beginning January 1, 2005, and ending June 30, 2005,**

are appropriated to the budget agency for its use in making the payments required by IC 27-8-10-2.1(g), as amended by this act, beginning January 1, 2005, and ending June 30, 2005.

SECTION 12. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1273, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 1 through 17.

Delete pages 2 through 4.

Page 5, delete lines 1 through 11.

Page 7, line 17, delete "Sue" and insert "**Subject to section 2.6 of this chapter,** sue".

Page 8, between lines 13 and 14, begin a new line block indented and insert:

"**(15) Subject to section 3 of this chapter, negotiate reimbursement rates and enter into contracts with individual health care providers and health care provider groups.**".

Page 9, line 5, delete "The following may".

Page 9, delete lines 6 through 12.

Page 9, line 13, delete "Forty percent (40%)" and insert "**Thirty-five percent (35%)**".

Page 9, line 13, delete "and one hundred percent".

Page 9, line 14, delete "(100%) of the expenses of administration of the association".

Page 9, line 27, delete "Sixty percent (60%)" and insert "**Sixty-five percent (65%)**".

Page 9, line 27, delete "and one hundred".

Page 9, line 28, delete "percent (100%) of any loss described in subdivision (2)".

Page 9, line 29, delete "department of insurance" and insert "**auditor of state**".

Page 9, line 37, strike "Except".

Page 9, line 38, strike "as provided in sections 12 and 13 of this chapter,".

Page 9, line 38, delete "net" and insert "Net".

Page 11, line 1, delete "annually" and insert "**periodically**".

Page 11, line 1, delete "department of" and insert "**auditor of state**".

Page 11, line 2, delete "insurance".

Page 11, line 2, delete "sixty percent (60%)" and insert "**sixty-five percent (65%)**".

Page 11, line 3, delete "and one hundred percent (100%) of any loss described in".

Page 11, line 4, delete "subsection (g)(2),".

Page 11, line 4, delete ";" and insert "**.**".

Page 11, line 6, delete "department of insurance" and insert "**auditor of state**".

Page 11, line 7, delete "amount" and insert "**amounts**".

Page 11, line 24, after "2.3." insert "**(a)**".

Page 11, line 30, after "2.1" insert "**(as in effect December 31, 2004) or 2.4**".

Page 11, between lines 31 and 32, begin a new paragraph and insert:

"**(b) A member shall, not later than October 31 of each year, certify an independently audited report to the association of the amount of assessments paid by the member against which a tax credit has not been taken under section 2.1 (as in effect December 31, 2004) or 2.4 of this chapter as of the date of the report.**

SECTION 4. IC 27-8-10-2.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2005]: **Sec. 2.4. (a) Beginning January 1, 2005, a member that, before January 1, 2005, has:**

(1) paid an assessment; and

(2) not taken a credit against taxes;

under section 2.1 of this chapter (as in effect December 31, 2004) is not entitled to claim or carry forward the unused tax credit except as provided in this section.

(b) A member described in subsection (a) may, in each calendar year beginning January 1, 2005, take a credit of not more than ten percent (10%) of the amount of the assessments paid before January 1, 2005, against which a tax credit has not been taken before January 1, 2005. A credit under this subsection may be taken against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of the member that may be imposed by the state, up to the amount of the taxes due for each calendar year.".

Page 11, line 32, delete "IC 27-8-10-2.4" and insert "IC 27-8-10-2.5".

Page 11, line 34, delete "2.4." and insert "**2.5.**".

Page 11, line 41, delete "IC 27-8-10-2.5" and insert "IC 27-8-10-2.6".

Page 11, line 42, delete "JULY" and insert "JANUARY".

Page 12, line 1, delete "2004]: Sec. 2.5." and insert "2004 (RETROACTIVE)]: **Sec. 2.6.**".

Page 12, line 17, after "(d)" insert "**The commissioner shall, not more than forty-five (45) days after an appeal is filed under subsection (c), take a final action or issue an order regarding the**

appeal.

(e)".

Page 12, delete lines 19 through 42, begin a new paragraph and insert:

"**(f) If a member sues the association, the court shall not award to the member:**

(1) attorney's fees or costs; or

(2) punitive damages.

SECTION 7. IC 27-8-10-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 15, 2004 (RETROACTIVE)]: Sec. 3. (a) An association policy issued under this chapter may pay **an amount for medically necessary eligible expenses related to the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter. Payment under an association policy may be based on the association's** usual and customary ~~charges~~ **fee schedule** or ~~use other~~ **another** reimbursement ~~systems that are consistent with managed care plans, including fixed fee schedules and capitated reimbursement, for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury that exceed the deductible and coinsurance amounts applicable under section 4 of this chapter.~~ **method or combination of reimbursement methods established by the board of directors. However, if the association adopts a fee schedule based on Medicare reimbursement, the fee schedule must provide for a reimbursement rate for inpatient and physician service eligible expenses of not less than the Medicare reimbursement rate for the eligible expenses plus eight and one-half percent (8.5%).** Eligible expenses are the charges for the following health care services and articles to the extent furnished by a health care provider in an emergency situation or furnished or prescribed by a physician:

(1) Hospital services, including charges for the institution's most common semiprivate room, and for private room only when medically necessary, but limited to a total of one hundred eighty (180) days in a year.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or, at the physician's direction, by the physician's staff of registered or licensed nurses, and allied health professionals.

(3) The first twenty (20) professional visits for the diagnosis or treatment of one (1) or more mental conditions rendered during

the year by one (1) or more physicians or, at their direction, by their staff of registered or licensed nurses, and allied health professionals.

(4) Drugs and contraceptive devices requiring a physician's prescription.

(5) Services of a skilled nursing facility for not more than one hundred eighty (180) days in a year.

(6) Services of a home health agency up to two hundred seventy (270) days of service a year.

(7) Use of radium or other radioactive materials.

(8) Oxygen.

(9) Anesthetics.

(10) Prostheses, other than dental.

(11) Rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed.

(12) Diagnostic X-rays and laboratory tests.

(13) Oral surgery for:

(A) excision of partially or completely erupted impacted teeth;

(B) excision of a tooth root without the extraction of the entire tooth; or

(C) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(14) Services of a physical therapist and services of a speech therapist.

(15) Professional ambulance services to the nearest health care facility qualified to treat the illness or injury.

(16) Other medical supplies required by a physician's orders.

An association policy may also include comparable benefits for those who rely upon spiritual means through prayer alone for healing upon such conditions, limitations, and requirements as may be determined by the board of directors.

(b) A managed care organization that issues an association policy may not refuse to enter into an agreement with a hospital solely because the hospital has not obtained accreditation from an accreditation organization that:

(1) establishes standards for the organization and operation of hospitals;

(2) requires the hospital to undergo a survey process for a fee paid by the hospital; and

(3) was organized and formed in 1951.

(c) This section does not prohibit a managed care organization from using performance indicators or quality standards that:

(1) are developed by private organizations; and

(2) do not rely upon a survey process for a fee charged to the hospital to evaluate performance.

(d) For purposes of this section, if benefits are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(e) The following are not eligible expenses in any association policy within the scope of this chapter:

(1) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(2) Services and charges made for benefits provided under the laws of the United States, including Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed in the future on behalf of all citizens by the United States.

(3) Benefits which would duplicate the provision of services or payment of charges for any care for injury or disease either:

(A) arising out of and in the course of an employment subject to a worker's compensation or similar law; or

(B) for which benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance.

However, this subdivision does not authorize exclusion of charges that exceed the benefits payable under the applicable worker's compensation or no-fault coverage.

(4) Care which is primarily for a custodial or domiciliary purpose.

(5) Cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure.

(6) Any charge for services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

(f) The coverage and benefit requirements of this section for association policies may not be altered by any other inconsistent state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

(g) This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits that, in the opinion of the board of directors, may be of benefit

to the citizens of Indiana.

(h) This chapter does not prohibit the association or its administrator from implementing uniform procedures to review the medical necessity and cost effectiveness of proposed treatment, confinement, tests, or other medical procedures. Those procedures may take the form of preadmission review for nonemergency hospitalization, case management review to verify that covered individuals are aware of treatment alternatives, or other forms of utilization review. Any cost containment techniques of this type must be adopted by the board of directors and approved by the commissioner.

SECTION 8. IC 27-8-10-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 3.2. Except as provided in section 3.6 of this chapter, a health care provider shall not bill an insured for any amount that exceeds:**

(A) the payment made by the association under the association policy for eligible expenses incurred by the insured; and

(B) any copayment, deductible, or coinsurance amounts applicable under the association policy.".

Delete pages 13 through 14.

Page 15, delete lines 1 through 9.

Page 15, delete lines 31 through 42, begin a new paragraph and insert:

"SECTION 10. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2004]: IC 27-8-10-12; IC 27-8-10-13.".

Page 16, delete lines 1 through 10.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1273 as introduced.)

FRY, Chair

Committee Vote: yeas 13, nays 0.

SENATE MOTION

Madam President: I move that Senator Broden be added as cosponsor of Engrossed House Bill 1273.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Finance, to which was referred House Bill No. 1273, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Replace the effective date in SECTION 8 with "[EFFECTIVE APRIL 1, 2004]".

Page 5, line 14, delete "July" and insert "**October**".

Page 5, line 23, delete "Thirty-five" and insert "**Twenty-five**".

Page 5, line 24, delete "(35%)" and insert "**(25%)**".

Page 5, line 36, delete "Sixty-five percent (65%)" and insert "**Seventy-five percent (75%)**".

Page 5, line 37, delete "auditor of state from the" and insert "**state.**".

Page 5, line 38, delete "appropriation made under subsection (p).".

Page 6, line 32, after "who" insert ",".

Page 7, line 9, delete "auditor of" and insert "**budget agency**".

Page 7, line 10, delete "state".

Page 7, line 10, delete "sixty-five percent (65%)" and insert "**seventy-five percent (75%)**".

Page 7, delete lines 12 through 14.

Page 7, line 18, delete "July" and insert "**October**".

Page 8, line 11, delete "in each calendar" and insert "**for each taxable year beginning after December 31, 2006,**".

Page 8, line 12, delete "year beginning January 1, 2005,".

Page 8, line 19, delete "calendar" and insert "**taxable**".

Page 8, between lines 19 and 20, begin a new paragraph and insert:

"**(c) The total amount of credits taken by a member under this section in all taxable years may not exceed the total amount of assessments paid by the member before January 1, 2005, minus the total amount of tax credits taken by the member under section 2.1 of this chapter (as in effect December 31, 2004) before January 1, 2005.**".

Page 8, line 31, after "If a" insert "**:**

(1)".

Page 8, line 32, delete "association," and insert "**association; or**

(2) health care provider is aggrieved by an act of the association with respect to reimbursement to the provider under an association policy;".

Page 8, line 32, beginning with "the member" begin a new line blocked left.

Page 8, line 32, after "member" insert "**or health care provider**".

Page 8, line 39, after "member" insert "**or health care provider**".

Page 8, line 41, after "member" insert "**or health care provider**".

Page 9, line 10, after "member" insert "**or health care provider**".

Page 9, line 11, delete ":" and insert "**or health care provider:**".

Page 9, line 20, delete "may" and insert "**must**".

Page 9, line 21, delete "the association's" and insert "**one (1) or any combination of the following reimbursement methods, as determined by the board of directors:**

(1) The association's usual and customary fee schedule in effect on January 1, 2004. If payment is based on the usual and customary fee schedule in effect on January 1, 2004, the rates of reimbursement under the fee schedule must be adjusted annually by a percentage equal to the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics during the preceding calendar year.

(2) A health care provider network arrangement. If payment is based on a health care provider network arrangement, reimbursement under an association policy must be made according to:

(A) a network fee schedule for network health care providers and nonnetwork health care providers; and

(B) any additional coinsurance that applies to the insured under the association policy if the insured obtains health care services from a nonnetwork health care provider.

(3) A fee schedule not described in subdivision (1) or (2). If payment is based on a fee schedule not described in subdivision (1) or (2), a health care provider must be reimbursed for medically necessary eligible expenses at a rate equal to the Medicare reimbursement rate for the eligible expenses plus eight and one-half percent (8.5%).".

Page 9, line 21, strike "usual and customary".

Page 9, line 21, delete "fee schedule".

Page 9, line 21, strike "or".

Page 9, line 22, delete "another".

Page 9, line 22, strike "reimbursement".

Page 9, line 27, delete "method or combination of reimbursement methods".

Page 9, delete lines 28 through 32.

Page 9, line 33, delete "one-half percent (8.5%).".

Page 9, line 33, after "(8.5%)." begin a new paragraph and insert:

"**(b)**".

Page 10, line 37, strike "(b)" and insert "**(c)**".

Page 11, line 4, strike "(c)" and insert "**(d)**".

Page 11, line 9, strike "(d)" and insert "**(e)**".

Page 11, line 12, strike "(e)" and insert "**(f)**".

Page 11, line 41, strike "(f)" and insert "**(g)**".

Page 12, line 3, strike "(g)" and insert "**(h)**".

Page 12, line 7, strike "(h)" and insert "**(i)**".

Page 13, between lines 6 and 7, begin a new paragraph and insert:

"SECTION 11. [EFFECTIVE JANUARY 1, 2005] **The amounts certified to the budget agency under IC 27-8-10-2.1(o), as amended by this act, beginning January 1, 2005, and ending June 30, 2005, are appropriated to the budget agency for its use in making the payments required by IC 27-8-10-2.1(g), as amended by this act, beginning January 1, 2005, and ending June 30, 2005.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1273 as printed January 30, 2004.)

BORST, Chairperson

Committee Vote: Yeas 14, Nays 0.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1273 be amended to read as follows:

Page 8, between lines 15 and 16, begin a new paragraph and insert:

"**(c) If the maximum amount of a tax credit determined under subsection (b) for a taxable year exceeds a member's liability for the taxes described in subsection (b), the member may carry the unused portion of the tax credit forward to subsequent taxable years. Tax credits carried forward under this subsection are not subject to the ten percent (10%) limit set forth in subsection (b).** ".

Page 8, line 16, delete "(c)" and insert "**(d)**".

(Reference is to EHB 1273 as printed February 20, 2004.)

MILLER